		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039305

Facility Name: LINDEN ESTATE

Address: 1000 LINDEN STREET (Number) MORTON (City) 61550 (Zip Code)

County: TAZEWELL

Telephone Number: (309) 266-9781 **Fax #** (309) 266-9468

IDPA ID Number: 23-7033585-004

Date of Initial License for Current Owners: 09/17/1994

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MATTHEW STEFFEN **Telephone Number:** (309) 266-9781

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2002 to 06/30/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) HELEN SCHUON
(Title) ADMINISTRATOR

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 12/01/1994

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less		5,840	6
7		TOTALS		5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,445			5,445	13
14	TOTALS	5,445			5,445	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.24%

D. How many bed-hold days during this year were paid by Public Aid? 198 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES [ ] NO [X]

I. On what date did you start providing long term care at this location? Date started 07/01/1994

J. Was the facility purchased or leased after January 1, 1978? YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year? YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2003 Fiscal Year: 06/30/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	28,843	1,864	1,677	32,384	(9)	32,375		32,375			1
2	Food Purchase		30,970		30,970		30,970		30,970			2
3	Housekeeping		1,530		1,530		1,530		1,530			3
4	Laundry		983		983		983		983			4
5	Heat and Other Utilities			12,706	12,706		12,706		12,706			5
6	Maintenance	12,438	1,165	3,926	17,529	(13)	17,516	(2,290)	15,226			6
7	Other (specify):*											7
8	**TOTAL General Services**	41,281	36,512	18,309	96,102	(22)	96,080	(2,290)	93,790			8
	B. Health Care and Programs											
9	Medical Director			234	234		234		234			9
10	Nursing and Medical Records	16,822	7,236	490	24,548	(1,308)	23,240		23,240			10
10a	Therapy	225,684		2,510	228,194	(117)	228,077		228,077			10a
11	Activities		545		545	43	588		588			11
12	Social Services		101	2,231	2,332	(843)	1,489		1,489			12
13	Nurse Aide Training					2,326	2,326		2,326			13
14	Program Transportation			1,815	1,815	(1,815)						14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	242,506	7,882	7,280	257,668	(1,714)	255,954		255,954			16
	C. General Administration											
17	Administrative	15,045			15,045	(20)	15,025		15,025			17
18	Directors Fees											18
19	Professional Services			3,198	3,198		3,198		3,198			19
20	Dues, Fees, Subscriptions & Promotions			1,188	1,188		1,188	(61)	1,127			20
21	Clerical & General Office Expenses	20,434	2,925	3,868	27,227		27,227		27,227			21
22	Employee Benefits & Payroll Taxes			91,023	91,023		91,023		91,023			22
23	Inservice Training & Education			442	442		442		442			23
24	Travel and Seminar			674	674		674	(760)	(86)			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			6,384	6,384		6,384		6,384			26
27	Other (specify):*			3,473	3,473	(3,473)						27
28	**TOTAL General Administration**	35,479	2,925	110,250	148,654	(3,493)	145,161	(821)	144,340			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	319,266	47,319	135,839	502,424	(5,229)	497,195	(3,111)	494,084			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number LINDEN ESTATE #0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			32,531	32,531		32,531		32,531			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			2,432	2,432		2,432	(2,432)				34
35	Rent-Equipment & Vehicles			37	37		37		37			35
36	Other (specify):*											36
37	**TOTAL Ownership**			35,000	35,000		35,000	(2,432)	32,568			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,815	1,815	(1,815)				38
39	Ancillary Service Centers					3,414	3,414		3,414			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,328	35,328		35,328		35,328			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			35,328	35,328	5,229	40,557	(1,815)	38,742			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	319,266	47,319	206,167	572,752		572,752	(7,358)	565,394			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(61)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,865)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,926)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,432)	34	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (2,432)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (7,358)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 1,815	14	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,815		47

LINDEN ESTATE

ID# 0039305

Report Period Beginning: 07/01/2002

Ending: 06/30/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Out of state travel	$ (760)	24	1
2	Offset travel income	(1,815)	38	2
3	Offset travel income	(2,290)	6	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,865)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LINDEN ESTATE # 0039305 **Report Period Beginning:** 07/01/2002 **Ending:** 06/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,290)	0	0	0	0	0	0	0	0	0	0	(2,290)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,290)	0	0	0	0	0	0	0	0	0	0	(2,290)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(61)	0	0	0	0	0	0	0	0	0	0	(61)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(760)	0	0	0	0	0	0	0	0	0	0	(760)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(821)	0	0	0	0	0	0	0	0	0	0	(821)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,111)	0	0	0	0	0	0	0	0	0	0	(3,111)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LINDEN ESTATE # 0039305 **Report Period Beginning:** 07/01/2002 **Ending:** 06/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(2,432)	0	0	0	0	0	0	0	0	0	0	(2,432)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,432)	0	0	0	0	0	0	0	0	0	0	(2,432)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(1,815)	0	0	0	0	0	0	0	0	0	0	(1,815)	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,815)	0	0	0	0	0	0	0	0	0	0	(1,815)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(7,358)	0	0	0	0	0	0	0	0	0	0	(7,358)	45

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Apostolic Christian Home for the Handicappe	100%	Apostolic Christian Timber Ridge	Morton	Community	Morton	Residential Service
		Oakwood Estate	Morton	Residential Services		for the Disabled

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Office rent	$ 2,432	Apostolic Christian Timber Ridge	100.00%	$ 2,432	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,432			$ 2,432	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Sauder	Chairman	Director	0.00		0.5			$		1
2	John Knobloch	Vice Chairman	Director	0.00		0.5					2
3	Dan Schumacher	Sec/ Treasurer	Director	0.00		1					3
4	Jerry Christensen	Director	Director	0.00		0.5					4
5	Ron Gasser	Director	Director	0.00	1,444	0.5		Travel	310	line 24;col.3	5
6	Jerry Kieser	Director	Director	0.00		0.5					6
7	Keith Pflum	Director	Director	0.00	613	0.5		Travel	132	line 24;col.3	7
8	Richard Steffen	Director	Director	0.00		0.5					8
9	Stan Virkler	Director	Director	0.00	350	0.5		Travel	76	line 24;col.3	9
10	Warren Zahner	Director	Director	0.00	1,726	0.5		Travel	374	line 24;col.3	10
11											11
12											12
13								TOTAL	$ 892		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Apostolic Christian Timber Ridge
Street Address: 2125 Veterans Rd.
City / State / Zip Code: Morton, IL 61550
Phone Number: (309) 266-9781
Fax Number: (309) 266-9468

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	34	Office rent	No. of residents	142	142	$ 22,205	$ 0	16	$ 2,464	1
2										2
3	6, 10a, 17, 21	Wages	Direct cost/ # of hours	1,516	1,516	25,770	25,770	1,516	25,770	3
4										4
5	22	Fringes	Direct cost	1,516	1,516	4,425	4,425	1,516	4,425	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 52,400	$ 30,195		$ 32,659	25

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Oakwood Estate
Street Address: 2213 Veterans Road
City / State / Zip Code: Morton, IL 61550
Phone Number: (309) 266-9781
Fax Number: (309) 266-9468

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	17	Wages	Direct cost/ # of hours	663	663	14,710	14,710	663	14,710	2
3										3
4	22	Fringes	Direct cost	663	663	1,545	1,545	663	1,545	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 16,255	$ 16,255		$ 16,255	25

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LINDEN ESTATE COUNTY TAZEWELL

FACILITY IDPH LICENSE NUMBER 0039305

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,848 B. General Construction Type: Exterior Brick Veneer Frame Wood Frame Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	16 bed home	87,120	1993	$ 52,959	1
2					2
3	TOTALS	87,120		$ 52,959	3

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			1994	$ 244,748	$ 8,145	30	$ 8,145	$	$ 79,189	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Garage			1994	25,345	1,014	25	1,014		10,139	9
10	Garage			1995	8,900	445	20	445		3,560	10
11	Generator wiring			1999	527	18	30	18		79	11
12	Fixed equipment			1994	107,762	5,833	ten-twenty five	5,833		55,213	12
13	Generator			2000	3,854	257	15	257		899	13
14	Land improvements			1994	92,728	5,051	ten-thirty	5,051		51,257	14
15	Lobby carpet			2001	1,256	84	15	84		209	15
16	Panasonic telephone system			2003	2,258	75	15	75		75	16
17	Livingroom carpet			2003	710	35	10	35		35	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 488,088	$ 20,957		$ 20,957	$	$ 200,655	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 68971	$ 7,077	$ 7,077	$	5-10yrs	$ 60,119	71
72	Current Year Purchases	752	25	25		15	25	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 69,723	$ 7,102	$ 7,102	$		$ 60,144	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Residents & in service	Lumina	2001	$ 11,679	$ 1,668	$ 1,668	$	7	$ 4,171	76
77	Residents & in service	2000 E350 Ford Van	2001	19,630	2,804	2,804		7	7,011	77
78										78
79										79
80	TOTALS			$ 31,309	$ 4,472	$ 4,472	$		$ 11,182	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 642,079	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 32,531	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 32,531	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 271,981	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)	680	527		1,207
4	Clinical Wages	(b)	340	1,054		1,394
5	In-House Trainer Wages	(c)	1,501	2,326		3,827
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 2,521	$ 3,907	$	$ 6,428
10	SUM OF line 9, col. 1 and 2	(e)	$ 6,428			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	7

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number LINDEN ESTATE # 0039305 **Report Period Beginning:** 07/01/2002 **Ending:** 06/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 400	$ 568,118	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 455)	84,846	993,203	3
4	Supply Inventory (priced at 3,289)	3,289	48,435	4
5	Short-Term Investments		3,564,361	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	859	42,931	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		40,624	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 89,394	$ 5,257,672	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	145,687	709,190	13
14	Buildings, at Historical Cost	395,361	3,532,876	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	100,627	1,777,034	16
17	Accumulated Depreciation (book methods)	(271,983)	(3,203,751)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	11,887	38,156	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(11,887)	(38,156)	20
21	Restricted Funds		2,814,024	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):		18,954	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 369,692	$ 5,648,327	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 459,086	$ 10,905,999	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,401	$ 57,092	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,147	339,455	30
31	Accrued Taxes Payable (excluding real estate taxes)		25,666	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	10,100	176,213	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 32,648	$ 598,426	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 32,648	$ 598,426	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 426,438	$ 10,307,573	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 459,086	$ 10,905,999	48

***(See instructions.)**

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 548,252	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 548,252	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	7,745	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Reduced Donated Capital from Other Entities**	(129,559)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (121,814)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 426,438	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 575,978	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 575,978	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	4,105	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,105	23
	D. Non-Operating Revenue		
24	Contributions	414	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 414	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 580,497	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	96,102	31
32	Health Care	257,668	32
33	General Administration	148,654	33
	B. Capital Expense		
34	Ownership	35,000	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	35,328	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 572,752	40
41	**Income before Income Taxes (line 30 minus line 40)****	7,745	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 7,745	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	745	745	16,822	22.58	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	74	74	830	11.22	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	174	237	2,990	12.62	14
15	Cook Helpers/Assistants	1,913	2,366	25,853	10.93	15
16	Dishwashers					16
17	Maintenance Workers	787	781	12,438	15.93	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	630	630	15,045	23.88	20
21	Assistant Administrator					21
22	Other Administrative	206	206	5,338	25.91	22
23	Office Manager					23
24	Clerical	936	936	15,096	16.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,891	2,106	32,628	15.49	29
30	Habilitation Aides (DD Homes)	16,983	19,034	191,713	10.07	30
31	Medical Records					31
32	Other Health C: OT/PT	35	35	513	14.66	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,374	27,150	$ 319,266 *	$ 11.76	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	25	$ 1,677	1-3	35
36	Medical Director	flat fee	234	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	flat fee	400	10-3	39
40	Physical Therapy Consultant	12	635	10a-3	40
41	Occupational Therapy Consultant	16	843	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	20	1,031	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	7	831	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	80	$ 5,651		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Helen Schuon		0	$ 13,055
Ron Messner		0	1,990
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 15,045

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heinold Banwart, LTD	Acctg. & Counseling	$ 2,458
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 2,458

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 11,756
Unemployment Compensation Insurance	
FICA Taxes	26,880
Employee Health Insurance	24,440
Employee Meals	14,284
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan	11,233
Employee Physicals	129
Employee Promotion	2,301
TOTAL (agree to Schedule V, line 22, col.8)	$ 91,023

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	48
(Indicate # of checks performed 4)	
Other dues	18
IHCA dues	826
Other subscriptions	235
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,127

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Board of Directors travel	760
In-State Travel	
Board of Directors travel	132
Administrative travel	137
Seminar Expense	
Less out of state travel	(760)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 269

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LINDEN ESTATE # 0039305 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association. - $826**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **14**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **35,328**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **12,447** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **1,815**
c. What percent of all travel expense relates to transportation of nurses and patients? **73%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Heinold-Banwart, Ltd.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **Report - Consolidated basis only**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Linden Estate
FYE 6/30/2003 **#0039305**
Subschedules

Schedule V - Reclassifications

Lines	Description	Amount Increase	Amount Decrease
11	Donated labor	59	
27	Donated labor		59
38	Medically necessary transporation	1815	
14	Medically necessary transporation		1815
13	Nurse aide trainer wages	2,326	
1	Nurse aide trainer wages		9
6	Nurse aide trainer wages		13
10	Nurse aide trainer wages		1,308
10a	Nurse aide trainer wages		117
12	Nurse aide trainer wages		843
11	Nurse aide trainer wages		16
17	Nurse aide trainer wages		20
39	Dental costs	3,414	
10	Dental costs		3,414
		7614	7614

Schedule V, Line 39 - Ancillary Service Centers

Dental costs for 36 visits	3,414

Schedule VI B, Line 31 - Non-paid workers

	Time in Hours	Time in Dollars
Activities - Donated Labor	10.75	59

Schedule VII - Compensation Received From Other Nursing Homes

Stan Virkler - $350 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate

Ron Gasser - $1444 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate

Keith Pflum - $613 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate

Warren Zahner - $1726 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Oakwood Estate

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation

Salaries, Sch V, Line 45, Col 1	319,266
Add accrued wages a/o 6/30/02	16,880
Less accrued wages a/o 6/30/03	(6,828)
Add wages included in employee meal calculation	6,526
Cash basis salaries	335,844
FICA rate	0.0765
Calculated FICA	25,692
FICA per Schedule XIX	26,880
Unknown variance	(1,188)

Sch. XVII - Income Statement, Line 41 - Income Before Taxes

Income before taxes per cost report	7,745
Income from related parties	372,473
Estimated excess for year, Form 990, p.1, line 18	380,218

Sch. XX - General Information

12. Nurse Aide Trainer Wages:

Administrator	20
PT/OT	117
Activities Director	16
Soc. Serv. / QMRP	843
Head Cook	9
Maintenance	13
Nursing	1,308
	2,326

16. Out of State Travel

Board of Directors	
Ron Gasser	310
Stan Virkler	76
Warren Zahner	374
	760

LINDEN ESTATE #0039305

ATTACHMENT TO SCH VII A

Related Organizations:

Apostolic Christian Timber Ridge, Morton, IL
Oakwood Estate, Morton, IL

Board of Directors for Apostolic Christian Timber Ridge, Oakwood Estate, and Linden Estate:

Edward Sauder, Chairman
John Knobloch, Vice Chairman
Dan Schumacher, Secretary/ Treasurer
Jerry Christensen, Director
Ron Gasser, Director
Jerry Kieser, Director
Keith Pflum, Director
Richard Steffen, Director
Warren Zahner, Director
Michael Dubach, Director

Note: The Board members are identical for all three organizations.

No members of the Board of Directors provided direct services to any of the nursing homes. No Board members have ownership in an entity that conducted business transactions with any of these nursing homes.

LINDEN ESTATE -- 0039305

	Salary/Wage	Supplies	Other	Total	Reclass-ification	Total	Adjust-ments	Adjusted Total	Cost / Day Resident Days 5,445	% of Total Costs	% of Rate
A. General Services											
Dietary	28,843	1,864	1,677	32,384	(9)	32,375	-	32,375	$5.95	5.7%	5.8%
Food Purchase	-	30,970	-	30,970	-	30,970	-	30,970	$5.69	5.5%	5.5%
Housekeeping	-	1,530	-	1,530	-	1,530	-	1,530	$0.28	0.3%	0.3%
Laundry	-	983	-	983	-	983	-	983	$0.18	0.2%	0.2%
Heat and Other Utilities	-	-	12,706	12,706	-	12,706	-	12,706	$2.33	2.2%	2.3%
Maintenance	12,438	1,165	3,926	17,529	(13)	17,516	(2,290)	15,226	$2.80	2.7%	2.7%
Other (specify):*	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%
TOTAL General Services	**41,281**	**36,512**	**18,309**	**96,102**	**(22)**	**96,080**	**(2,290)**	**93,790**	**$17.22**	**16.6%**	**16.7%**
B. Health Care and Programs											
Medical Director	-	-	234	234	-	234	-	234	$0.04	0.0%	0.0%
Nursing and Medical Records	16,822	7,236	490	24,548	(1,308)	23,240	-	23,240	$4.27	4.1%	4.1%
Therapy	225,684	-	2,510	228,194	(117)	228,077	-	228,077	$41.89	40.3%	40.7%
Activities	-	545	-	545	43	588	-	588	$0.11	0.1%	0.1%
Social Services	-	101	2,231	2,332	(843)	1,489	-	1,489	$0.27	0.3%	0.3%
Nurse Aide Training	-	-	-	-	2,326	2,326	-	2,326	$0.43	0.4%	0.4%
Program Transportation	-	-	1,815	1,815	(1,815)	-	-	-	$0.00	0.0%	0.0%
Other (specify):*	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%
TOTAL Health Care and Programs	**242,506**	**7,882**	**7,280**	**257,668**	**(1,714)**	**255,954**	**-**	**255,954**	**$47.01**	**45.3%**	**45.7%**
C. General Administration											
Administrative	15,045	-	-	15,045	(20)	15,025	-	15,025	$2.76	2.7%	2.7%
Directors Fees	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%
Professional Services	-	-	3,198	3,198	-	3,198	-	3,198	$0.59	0.6%	0.6%
Dues, Fees, Subscriptions & Promotions	-	-	1,188	1,188	-	1,188	(61)	1,127	$0.21	0.2%	0.2%
Clerical & General Office Expenses	20,434	2,925	3,868	27,227	-	27,227	-	27,227	$5.00	4.8%	4.9%
Employee Benefits & Payroll Taxes	-	-	91,023	91,023	-	91,023	-	91,023	$16.72	16.1%	16.2%
Inservice Training & Education	-	-	442	442	-	442	-	442	$0.08	0.1%	0.1%
Travel and Seminar	-	-	674	674	-	674	(760)	(86)	($0.02)	0.0%	0.0%
Other Admin. Staff Transportation	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%
Insurance-Prop.Liab.Malpractice	-	-	6,384	6,384	-	6,384	-	6,384	$1.17	1.1%	1.1%
Other (specify):*	-	-	3,473	3,473	(3,473)	-	-	-	$0.00	0.0%	0.0%
TOTAL General Administration	**35,479**	**2,925**	**110,250**	**148,654**	**(3,493)**	**145,161**	**(821)**	**144,340**	**$26.51**	**25.5%**	**25.8%**
TOTAL Operating Expense	**319,266**	**47,319**	**135,839**	**502,424**	**(5,229)**	**497,195**	**(3,111)**	**494,084**	**$90.74**	**87.4%**	**88.1%**
D. Ownership											
Depreciation	-	-	32,531	32,531	-	32,531	-	32,531	$5.97	5.8%	5.8%
Amortization of Pre-Op. & Org.	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%
Interest	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%
Real Estate Taxes	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%
Rent-Facility & Grounds	-	-	2,432	2,432	-	2,432	(2,432)	-	$0.00	0.0%	0.0%
Rent-Equipment & Vehicles	-	-	37	37	-	37	-	37	$0.01	0.0%	0.0%
Other (specify):*	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%
TOTAL Ownership	**-**	**-**	**35,000**	**35,000**	**-**	**35,000**	**(2,432)**	**32,568**	**$5.98**	**5.8%**	**5.8%**
Ancillary Expense											
E. Special Cost Centers											
Medically Necessary Transportation	-	-	-	-	1,815	1,815	(1,815)	-	$0.00	0.0%	0.0%
Ancillary Service Centers	-	-	-	-	3,414	3,414	-	3,414	$0.63	0.6%	0.6%
Barber and Beauty Shops	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%
Coffee and Gift Shops	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%
Provider Participation Fee	-	-	35,328	35,328	-	35,328	-	35,328	$6.49	6.2%	6.3%
Other (specify):*	-	-	-	-	-	-	-	-	$0.00	0.0%	0.0%
TOTAL Special Cost Centers	**-**	**-**	**35,328**	**35,328**	**5,229**	**40,557**	**(1,815)**	**38,742**	**$7.12**	**6.9%**	**6.9%**
GRAND TOTAL COST	**319,266**	**47,319**	**206,167**	**572,752**	**-**	**572,752**	**(7,358)**	**565,394**	**$103.84**	**100.0%**	**100.9%**
Current Reimbursement Rate									**$102.94**	**99.1%**	**100.0%**
Gain/(Loss) Per Resident / Day									**(0.90)**	**-0.9%**	**-0.9%**
% of Costs Per Area	**71.63%**	**8.26%**	**20.10%**	**100.00%**